

No. 2
11-10-39
5-17-39
I X21402

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30129**
Registrar's No. **7406**

Registration District No. **791**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Central Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Day**
(Specify whether
In this community **40yrs**
years, months or days)

8. (a) PRINT FULL NAME **John W DeTurk**

8. (b) If veteran, name war **None** 8. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Jessie** 6. (c) Age of husband or wife if alive **50** years

7. Birth date of deceased **Oct 22nd, 1885**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 10 10 hr. min.

9. Birthplace **Hannibal Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Live Stock Dealer**

11. Industry or business _____

12. Name **Philip DeTurk**

13. Birthplace **N.Y.**
(City, town, or county) (State or foreign country)

14. Maiden name **Marie L Worthington**

15. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Jessie DeTurk**
(b) Address **510 Walton Ave**

17. (a) **Burial** (b) Date thereof **9/4/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cent**

18. (a) Signature of funeral director **Harrigan & Sheahan Und Co**
(b) Address **4415 Washington Blvd**

19. (a) **SEP 3 1940**
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County _____
(c) City or town **St. Louis** **12**
(If outside city or town limits, write "RURAL")
(d) Street No. **510 Walton Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **Life** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2nd** day **Sept**
year **1940** hour **4:00** P.M. M.

21. I hereby certify that I attended the deceased from **Sept 2**
19 **40** to **Sept 2** 19 **40**
that I last saw him alive on **Sept 2** 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion 2 day**
Duration

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **was done - certificate per findings**

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury **!**

23. Signature **T J Kump** (M. D. or other)
Address **4503 Washington** Date signed **Sept 3 1940**

PHYSICIAN
Underline the cause to which death should be charged statistically.

At Brawley

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Guy W Wilkinson
Licensed Embalmer No. 3578

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

-If this body is not embalmed, above space should be left blank.